OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 13 September 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 13 September 2016

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HEALTH AND SPORT COMMITTEE
4th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Nicky Connor (NHS Fife)
Jim Fordyce (Hazelhead Care)
Anna Fowlie (Scottish Social Services Council)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Dr Donald Macaskill (Scottish Care)
Iain Ramsay (Aberdeenshire Health and Social Care Partnership)
Dave Watson (Unison)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 13 September 2016

[The Convener opened the meeting at 10:15]

Social and Community Care Workforce

The Convener (Neil Findlay): Good morning, everyone. Welcome to the fourth meeting in 2016, in the Scottish Parliament's fifth session, of the Health and Sport Committee. I ask everyone in the room to switch off their mobile phones as they can interfere with the sound system.

We have apologies from Donald Cameron, who is slightly delayed this morning. I will not tell you why. Actually, I will: his daughter has locked the car keys in the car. [*Laughter*.] Just smile when he comes in.

Agenda item 1 is evidence on the social and community care workforce. Before we begin, I note that the committee met front-line social and community care staff earlier this morning. I thank them for taking time out of their day to tell us their experiences of working in the sector. It was a very helpful and informative session. Do any of my colleagues want to comment very briefly on that?

Ivan McKee (Glasgow Provan) (SNP): The session was very helpful. The staff's forthright views illuminated the issues that they face.

Clare Haughey (Rutherglen) (SNP): The staff were very frank with us, and they are to be congratulated on coming along this morning and representing their workforce.

The Convener: Yes, it was a very good session.

We move to our evidence session on the social and community care workforce. I ask people around the table to introduce themselves. I am the convener of the Health and Sport Committee.

Clare Haughey: I am the deputy convener of the Health and Sport Committee.

Jim Fordyce (Hazelhead Homecare Ltd): Hello. I am the managing director of Hazelhead Homecare Ltd, which provides care-at-home services.

Tom Arthur (Renfrewshire South) (SNP): I am the MSP for Renfrewshire South.

Miles Briggs (Lothian) (Con): Good morning. I am an MSP for the Lothian region.

Dr Donald Macaskill (Scottish Care): I am the chief executive of Scottish Care, which is a national membership organisation of providers of older people's care and support.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, everyone. I am the MSP for Edinburgh Western.

Dave Watson (Unison): Good morning. I am the head of policy and public affairs at Unison Scotland. We represent care staff.

Richard Lyle (Uddingston and Bellshill) (SNP): Morning. I am the MSP for Uddingston and Bellshill.

Nicky Connor (NHS Fife): I am the associate director of nursing in the health and social care partnership in Fife.

Alison Johnstone (Lothian) (Green): I am a Lothian MSP.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): Hello. I am from the Coalition of Care and Support Providers in Scotland, which is the membership association for third or voluntary sector providers. I am also a non-executive director of the Scottish Government, but I am not here in that capacity today. I am a Unison member.

Maree Todd (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands region.

Iain Ramsay (Aberdeenshire Health and Social Care Partnership): I am from the Aberdeenshire health and social care partnership.

Colin Smyth (South Scotland) (Lab): Good morning. I am an MSP for the South Scotland region.

Anna Fowlie (Scottish Social Services Council): Good morning. I am the chief executive of the Scottish Social Services Council. We are the regulator for the social care and social work workforce, as well as the sector's lead for workforce development.

Ivan McKee: I am MSP for Glasgow Provan.

The Convener: Thank you very much, folks. We want this to be a lively, interactive session, rather than a formal evidence session like the ones that we usually have. I am happy for people to jump in. We have about 75 minutes for the session. Brief contributions would be helpful, and not everyone need contribute on every topic. It would be helpful if committee members could indicate when they want to move on to another topic.

Alison Johnstone will kick off.

Alison Johnstone: Thank you, convener. I think that it is fair to say that we all learned a lot

earlier this morning when we heard directly from those who are working in the delivery of care in our communities. It is clear that workforce planning is an issue. I heard from one worker who had undertaken 31 visits to different people on Sunday, which is a fairly hefty workload, and I heard about a lot of 7 am to 10 pm shifts. There was a feeling among some organisations that that was due to a lack of staff. A lot of overtime is required for what is clearly a very responsible task. What are the main barriers to effective planning of the workforce? It seems that there are several. I am not sure to whom to direct that question in the first instance, convener.

The Convener: Who would like to jump in?

Jim Fordyce: Workforce planning in respect of what Alison Johnstone described is something that we look at often. The situation on Sunday that she spoke about is something that we see quite a lot.

Our organisation's full-time workers work three out of four weekends. Nearly every other organisation that we come across has people working one in every two weekends. I just cannot see how it is possible to do that. We have always gone with three in four weekends to ensure that we have the same number of people in the workforce throughout the week. That is the type of thing that we, as an organisation, look at specifically.

Alison Johnstone: I heard a fair amount about how many organisations are relying on agency workers. That obviously has an impact on continuity of care, which can be quite distressing for those who have dementia. I left this morning's session thinking that we do not have enough people working in care. I also note that there is a variety of training on offer for those who are working in the field.

Dr Macaskill: The use of agency staff is a matter of considerable concern for many of our members. Agency staff can be helpful during transitional periods, at holiday time or for relief, but we certainly have profound concerns, particularly with regard to the use of agency staff to fill nursing posts, about the lack of continuity of care. As Alison Johnstone highlighted, for somebody who may be living with dementia, continuity of care is fundamentally important.

Organisations do not want to use agency staff, not least because they are considerably more expensive. I heard last week of one provider that paid £800 an hour—sorry, I meant £800 a night; it is bad enough but not that bad—for a nursing shift. That is not a good business model: it does not provide continuity, it is not good for colleagues to see somebody being brought in, and the individual who is brought in on a short-term basis does not know the individuals whom they are supporting.

We have a critical shortage of some elements of social care and nursing staff. That is all bound up with our ability to recruit and retain staff, which we are not at present able to do in the numbers that would lead to a reduction in the use of agencies.

Alison Johnstone: Can I ask for a bit more focus on what you see as the main barriers to recruitment?

Dr Macaskill: There are a lot of barriers. I took part last year in a project called voices from the front line, and I was privileged, along with colleagues from Scottish Care, to interview a number of front-line workers, just as the committee has been privileged to meet such workers this morning. To a man and woman, they are dedicated individuals who give of their life to provide care and support for individuals. However, there are aspects that make those workers think about whether they can continue in their job. One of those aspects is the terms and conditions. The fact that, from 1 October, we will be able to pay the Scottish living wage in most parts of Scotland will go a long way towards meeting that particular need, but there are other issues that need to be addressed, such as terms and conditions, training, and learning and development.

Fundamentally—and we cannot escape this reality—we must accept that many individuals do not find working with people in care attractive. Society—and Scotland as a whole—does not value those who work in caring for old people, in the case of our organisation, or in caring for many other individuals. Even if we attend to the fundamentally important issue of proper terms and conditions, we collectively need to do a lot more to advance the value of those who care for people—and we are just not doing that.

The Convener: I wonder whether we can talk about this issue of being undervalued, which has come up time and again this morning.

Annie Gunner Logan: Just to add to what Donald Macaskill has said about recruitment, which is certainly an issue, I think, more generally, that the numbers of people who might be required in the future to make the sector sustainable will present quite a challenge. At one point, the Scottish Government came out and said that it would not be very much longer before every single school leaver would have to go into the care sector if it was to be kept afloat. One of the things that our members are looking very carefully at is service redesign, because we cannot keep going in and providing care and support in the way that we are providing it at the moment. We therefore need to figure out a different way of doing this, and we in the voluntary sector are very interested in the potential of self-directed support in that respect.

With regard to the question about barriers, you will know, convener, that it does not take me long to get round to the commissioning and procurement of care and support, and one issue is the way in which care is commissioned on framework contracts. It used to be much more the case that a provider would get a contract for a service with a certain number of hours and a certain number of people to support, and they could plan their workforce around that. Increasingly, providers are being accepted on to a framework, which means that they have no sense of, say, the number of people they might have to support in future or the number of hours of support that they might have to provide. In those circumstances, it is very difficult to carry out forward planning for the workforce. As a result, we want not just service redesign but a redesign of the way in which care is commissioned, because we think that that is quite a significant barrier.

Dave Watson: I largely agree with that. If you have had a chance to read our latest survey of care staff—"We care, do you? A Survey of care workers in Scotland"—you will have seen some things that are pretty similar to what you have heard this morning. The report essentially takes the voices of front-line care workers and explains their concerns. Fundamentally, there are just not enough staff. That is the bottom line. As staff will tell you, even when they have finished their shift, they will get a phone call from someone saying, "Can you do another one?" or "Can you squeeze another one in?" In other words—to put it bluntly—people who are supposed to get a 30-minute visit get a 20-minute visit instead, because the care worker has to try to squeeze in another visit that has not been scheduled.

Linked very closely to that is the fact that—and I agree with Annie Gunner Logan on this—a lot of travel time is not taken into account in many of the programmes. That means that although a person is in theory getting a 30-minute visit, they are actually getting only a 20-minute visit when travel time is allowed for.

The other big problem is that because of the perceived lack of attractive job prospects in the sector, by which I mean pay and so on, turnover is very high, even among the better employers. I am not just talking about the worst in the sector; I have seen turnover rates of nearly 25 per cent in some of our better employers. That is call-centre standard, and that sector is notorious for having high turnover rates. You cannot provide continuity of care, particularly to elderly people, if, as is the case, they are being seen by a different carer almost every week.

With regard to barriers, pay and conditions are important, but we need to see this as an all-workforce issue. As we have pointed out, the Scottish Government's guidance on procurement makes it clear that local authorities should be procuring on all-workforce issues such as pay and conditions, travelling time and training. All those things should be taken into account and, frankly, that is not happening.

We also need to remember that we need to attract about another 60,000 care workers into the sector in the coming years. If we cannot recruit at the moment, where will the next 60,000 come from? I do not dare mention Brexit—you might want to talk about that later—but I should point out that a lot of these workers are European Union nationals. That is another issue that we need to face.

I have done a number of focus groups with our members in this area and the reality is that, if you talk to these people face to face—there are two spikes in the sector, with a group in their late 40s and early 50s and another in their late 20s and early 30s—the older members of staff tend to say, "Well, I'll probably hang on to retirement," while the younger members of staff will say, "This is not an attractive job, Dave. If I can get better money stacking shelves in a supermarket, that's where I am going."

Nicky Connor: Some important issues have been drawn out already. For example, colleagues have referred to nursing and the quality and continuity of care. A huge amount of work is happening nationally in the district nursing review, the out-of-hours review, the development of clusters and locality working in general practice. I absolutely agree with my colleagues that it is a whole-workforce issue. It is about how we work together and how we develop skills and make best use of the skills that everybody has so that we get best value out of everyone's contributions to meet the needs of people within the community setting.

10:30

Ivan McKee: An interesting point was raised at the meeting with care workers this morning. One of the care workers said that part of the problem was that they could be on for a 12 or 13-hour day but they might be working for just seven or eight hours of that day. A number of things follow on from that. It discourages people from staying in the profession when they realise that they can go and do a 12-hour shift in Asda and get paid for every one of those hours. Clearly, it is a logistics planning issue, which I know can be challenging. Also, there is unused capacity if people are in that situation. I wonder whether the panel members wish to comment on that.

Secondly, I have a question about self-directed support, which I do not know a lot about. It is interesting that Annie Gunner Logan mentioned

that. If we look at it at a macro level, are we not just saying, "Yes, we have a problem—let's move the problem somewhere else?" At the end of the day, if the individual patient hires somebody to do that job, they are still hiring from the same pool of people who do that kind of work, so we are not fixing the root cause of the problem; we may just be moving it to somebody else.

Annie Gunner Logan: That is a fair point. The thing to understand about self-directed support is that it is not necessarily about an individual hiring their own personal assistant. There are other things that people can do—they can buy in care from an agency; they can be much more flexible about what they do.

On the working hours issue that you mention, self-directed support raises questions about how we can provide personalised care for people who will want to choose when they want support and at what time, which will not necessarily be at the time that the council wants to send somebody around. It is about how employers can employ people on the fair work principles at the same time as being completely responsive to individuals who do not want care from 9 to 5, Monday to Friday. They might want support at odd times and then not at others.

I am sure that the committee will be aware of the fair work convention, which has been established to advise the Government on fair work principles. My understanding is that the convention wants to look very specifically at the issue of social care personalisation and fair work and how we actually manage that, so that might be one to watch.

Alex Cole-Hamilton: I wish to explore further the issues with self-directed support. The vision of SDS gathered cross-party support in terms of service redesign to answer the very real and present threat—the perfect storm, if you like—of the ageing demographic, the decline in the workforce, and all the other issues that we have heard about this morning.

Could the panel members around the table explore how they think that SDS is working out and, in particular, the impact on the commissioning environment? We heard at the NHS Lothian briefing on Friday that some providers have aggressively recruited their patients into SDS to avoid commissioning. Also, there is a mixed picture out there on what is available, so someone may have a choice to take on full control of their budget but if there is only a sole provider in a rural region, there is no point in doing that because they will get the service that was already being provided.

Dr Macaskill: I think that you are right that, as the committee will know, SDS had cross-party support. I personally believe that SDS has the potential to be among the most innovative answers to some of the challenges that we are facing. However, we are not maximising the opportunities that the Social Care (Self-directed Support) (Scotland) Act 2013 gave us. One of the problems is that we talk about SDS over here and we talk about social care assessment over there, but there is only one type of assessment for somebody who requires social care support and that is under the self-directed support act.

Are we maximising the opportunities that are offered by all four options in the act? No. Is there a piecemeal approach in different parts of the country? Certainly. Among those whom I support—our older citizens—self-directed support is underused. There is almost the presumption that what might be additional engagement through planning your own support and life is something for those under the age of 65. That is a very false assumption. We and our members know that lots of older people would like much greater control over their personal budgets, which would enable them to lead increasingly independent lives. There is therefore potential that we have not maximised, which necessitates, as Annie Gunner Logan said, looking at the way in which we commission and procure services. If we commission an organisation to provide 15-minute or half-hour support to an individual, that is not going to enable the holistic, person-centred approach that the 2013 act envisaged.

The Convener: Will self-directed support close or widen the gap in health inequality? My view is that SDS has the potential to widen the gap for some people because they will not know how to organise SDS and they will not have the family support or a framework around them, so they will not get that SDS advantage that other people might get.

Dr Macaskill: In essence, the Social Care (Self-directed Support) (Scotland) Act 2013 was about the reverse of that; it was about creating equality of opportunity so that those who are articulate and have family connections are not most advantaged. However, a system in which people have increased choice, information around that choice and support to be able to make it, will lead to better personal outcomes. I hope that I am not dreaming when I think that it is possible for the 2013 act to reduce health inequality by giving people the sort of service and support that they really need and which will, clinically and personally, achieve better outcomes for them.

We have a long way to go. We have been so focused on getting the system of integration right that we have taken our eye off the potential of self-directed support, so we need to refocus that attention.

Colin Smyth: I want to come back to recruitment and retention with regard to the point that Dr Macaskill made earlier about the fact that the Scottish living wage kicks in from 1 October. I am keen to hear any observations on that process—in particular, on how the process of introducing it has gone, because obviously there is a big requirement for negotiations on commissions and contracts. I am keen to know whether that process has gone smoothly and whether the allocation of resources to deliver the Scottish living wage has been sufficient for providers. Looking beyond the living wage, what other specific measures could be introduced to boost recruitment and retention?

Dr Macaskill: There is no one answer to that range of questions. In terms of how the process is going, it depends on which part of the country you are in. I will take two different groups from my sector, starting with the care home sector. As a result of the national care home contract, every care home in Scotland that has signed up to the contract will from 1 October be in a position to pay staff the Scottish living wage. That has been part of the national negotiation process. However, there have been challenges in the sector, because the settlement did not allocate moneys to take account of differentials. That is critically important because if we want, as you will have heard this morning, to create social care as a pathway and career of choice, then simply paying and allocating moneys to pay the Scottish living wage to the people at entry level does not enable that career to be established. Providers are having to eat into their assets, training budgets and reserves, which might have gone to further service development, or to pay enhanced rates to a supervisor or manager, but it is a short-term fix for a fundamental problem.

On the other hand, we have the care at home and housing support sector. Because we are in that system of local commissioning and procurement, the answer to Mr Smyth's question will depend on the part of the country that you are in. We in Scottish Care have significant concerns about providers in a good number of areas having, on 1 October, to choose to reduce terms and conditions in order to pay the baseline Scottish living wage, and about providers in other parts of the country not being able to pay the Scottish living wage because the offer from the local authority and integration joint board is such that their doing so will be unsustainable and non-viable.

The concern in my membership organisation is that the challenge is faced particularly by the majority—the small and medium-sized enterprises and family-run businesses. Businesses that operate only in one area and whose staff base is only in that area will not have the economy of scale that would make it possible to balance that area against another in order to give a better package or deal.

Lastly, we have concerns about the introduction of percentage uplifts, which sound and look fair but are equitable only if providers start from the same baseline. If one provider in a local authority area is being paid £11 an hour for care and support and another is being paid £15 an hour, the guy at £15 an hour will, with a 2 or 3 per cent uplift, be able to pay the living wage viably without restricting staff conditions, while the person at £11 an hour will not. Those £11 an hour folks are our small and medium-sized high-quality organisations, and although I realise that negotiations are on-going, I am profoundly concerned that, in some parts of Scotland, the aim will not be achieved.

Anna Fowlie: I want to comment on personal assistants; as Annie Gunner Logan pointed out, that is only one aspect of the self-directed support legislation. If we are hanging a lot on growing capacity through personal assistants, we really have to look at them in the context of fair work. Those people are very vulnerable and they work with people who are vulnerable. Yes—the service users are vulnerable, but the personal assistants themselves are not subject to the living wage agreement. I should at this point say that it is a myth that all social services workers are getting the living wage. That is not the case—only some specific workers will get it. People who work in adult day care or with children, for example, are not getting it or are not part of that particular commitment. I feel that personal assistants will be last in the queue, because they are individuals and, like much of the workforce, are not organised or unionised. They are therefore very vulnerable. I worry about them in that context.

On the living wage itself and Donald Macaskill's point that we do not value workers, I, too, feel that we do not value people who work in care and that we do not regard them in the same way as we regard teachers, nurses or other workers, including even footballers. How shocking is that? However, we also do not value the people with whom they work, and that has a knock-on effect. The fact that we in this country do not particularly value old people or children is a real indictment of our society. Until we can change that, we will not manage to get people to work in the sector, because they need to feel that they are doing something valuable.

I also point out that the only time that *The Guardian* had heard the word "joy" mentioned in one of its staff surveys was in the "The view from here" project that the Institute for Research and Innovation in Social Services did with that newspaper. The staff to whom they talked to loved

what they did, but they felt exploited; the only people they felt valued by were the people who used their services and the people they worked with. That brought them joy, and the question is how we can harness that and make that more recognised in society.

The Convener: Those comments very much reflect what we heard this morning.

Iain Ramsay: Forgive me, but I can speak only on behalf of Aberdeenshire, so I will be taking quite a parochial approach.

With regard to the original question on workforce challenges, the dynamic is different in almost every part of Scotland. In Aberdeenshire, for example, we have a very rural geography, and it is incredibly difficult to recruit all types of health and social care staff to that sort of rural environment. The economics of the north-east also play in. We still have a buoyant oil and gas industry, and house prices are still relatively high, too. It is therefore difficult to attract people.

One of the key questions is how we value staff across health and social care partnerships, and that fundamental aspect has not been addressed properly for some time now. Through health and social care integration, we are developing properly integrated teams and a one-team approach to ensure that health and social care staff, including general practitioners, actually feel part of a team. For a long period, people such as home carers and support workers have been seen as being outwith that team. We now have an opportunity in Aberdeenshire to draw those individuals into the team and to make them feel valued and respected in that environment.

10:45

Maree Todd: Some of the people to whom we spoke this morning made exactly that point—that part of the value is in relationships. I am glad that you are doing things that way in Aberdeenshire. I keep saying this, but we should be looking north.

I get a sense that, in the caring environment, probably more value is placed on childcare. More training is available, there is more regulation and there are more obvious career paths. Do you agree? Is that an issue? In terms of valuing people, providing training is one of the main ways to invest in staff, so I am interested to hear what you think about training and career progression.

Jim Fordyce: I am a care-at-home provider and employer. As managing director, I take two days a week to interview front-line care workers. That is the most important part of my job and it is what I spend the biggest part of my time doing. There was a question earlier about barriers to entry and a lot of points about acceptance of the importance of the job have been discussed. For care-at-home providers, we need people who are mobile—in particular, people who are car drivers, so it is interesting that one of the huge barriers to people's entry into the sector is that they cannot drive. That might seem funny, but I need people who can drive. I also need people who can work what are termed "unsocial" hours at weekends and in the evenings. I tell people at interview that we need to provide services when people want them and not when we want to provide them. When we look at what we actually need to provide services in the care-at-home setting, we can see that that starts to limit our choice in respect of who can enter the profession, irrespective of whether people are physically able to do the job.

Another barrier is that we live in a society in which it is to a certain extent acceptable, especially in a home setting, for female workers to provide personal care, which is a huge part of our job, to both male and female service users, but that is not necessarily the case for male workers. Therefore, there is an imbalance built into the numbers in absolute terms. When I do my workforce planning, I cannot take on men and women on a 50:50 basis. A much higher number of women enter the workforce. You can see the whittling down of the types people who can do the job.

I see the £8.25 minimum wage as a start, but it could actually be transformational in our industry. That being the starting point and there being progression within organisations could begin to reflect the importance of the job of the care worker.

Anna Fowlie: I want to address Maree Todd's point about comparative levels of training and regulation. There is actually more regulation of workers in the social service workforce than there is in the health sector. In terms of social care, we regulate everyone who works in care homes at the moment. All managers across social services are regulated, and workers in care-at-home services will be regulated from next year. Everyone on our register must have minimum qualifications, although people have time to get the qualifications. Currently, we are going through that with people who work in care homes. Over time, everyone will have to have minimum qualifications, so people are getting those now. All the managers already have to have management qualifications. There is a difference between the sectors.

People's experience of training, especially for care at home, will vary across the country, but there are minimum standards and requirements that staff have to meet.

Dr Macaskill: We are increasingly making social care a career of choice. There is a tremendous opportunity for the future. If we are to

meet the needs of the national clinical strategy and the out-of-hours strategy, and if we are to realise the potential of integration, staff in the community and in care homes will need to be upskilled to develop increased capacity and ability. There is the potential for positive careers in care, but we need to give all the value in terms both of conditions and of other elements of service.

The Convener: I think that we all agree that potential exists but that we are, judging from the evidence that we have heard this morning, a long way from realising that potential.

Annie Gunner Logan: I want to come back on a couple of points that were made by Maree Todd. I will give the committee a copy of our report "2015 Benchmarking Report for Voluntary Sector HR Network and CCPS". The voluntary sector providers are committed to training and development, and one of the encouraging things in that report was that nearly 70 per cent of the providers that we surveyed had managed to keep their development and training budget stable, or had increased it. The sector has been not without its struggles, but if you are looking to make care an attractive career you must invest in developing the workforce. In our sector that is quite a high priority.

I will return briefly to the question on the living wage. As members will know, my organisation has campaigned for the living wage for a very long time—we have probably led the debate on it, over the years, by producing evidence of the impact of pay and conditions on quality—so we were absolutely delighted when the initiative was announced, back in February. To be honest, however, I have to say that we were less delighted to read about it in the paper than we would have been to be involved in the decision making around it. Providers were not involved in the decisions about the amount of resource that would be allocated, and we were not involved in the setting of dates for implementation, so, at this point, we are struggling to get over the bar. A lot of providers are confident that they will make it, but there are some challenges, which Donald Macaskill set out.

Part of the challenge was that the resource that was allocated did not account for differentials within organisations, which can be huge if we are talking about career progression and development. It also did not include on-costs for employers, including national insurance and pension contributions. There was an assumption that providers would find a contribution to make to the initiative, but we are really struggling with that in the not-for-profit sector. We are working through the issues in partnership with the Convention of Scottish Local Authorities and the Scottish Government, with me, Donald Macaskill and Unison around the table, but I would not say that it is easy.

On 1 September, with one month to go, we took some soundings from our members. The majority of them were struggling to arrive at appropriate funding agreements because, as the committee has heard, the money was allocated through local authorities and integration joint boards in order that they could contract locally with providers. We advocated a national approach, but that was not taken. The approach that we advocated was less about the amount of money that goes into staff pockets—that is something for employers to deal with—than it was about how much we pay for public services and the enabling factor that allows providers to pay the living wage. That approach was not taken, so there are some hurdles to overcome and we will take more soundings over the coming weeks. We are hopeful yet cautious.

Dave Watson: It is absolutely right to say that training is key, although in our experience it is a bit patchy. I am particularly concerned about induction training in home care areas. I frequently get people ringing up when their daughter or son has started work but has not been given an adequate induction before being sent out into fairly complicated care situations. In addition, staff often tell us that they are told to undertake refresher training, on-going training or continuing professional development on their day off, which is not how it should happen. There are issues.

The point about rural areas is well made. Last week, I talked to a social worker who said she had rung five providers about providing a package for an elderly person who needed hospital care, but several of the providers said, "We don't do villages." I should say that it was a rather rural local authority. She was not very impressed by that, but it reflects the challenges that providers face in getting people out to such places, where travelling times are a huge issue.

On Colin Smyth's question, I largely agree with Annie Gunner Logan's response. To be clear, we welcome the Scottish Government's commitment to the £8.25 an hour living wage from 1 October. That is absolutely the right policy, but the difficulty concerns its delivery. We were told that £250 million was allocated in the budget for social care, but we were not told how that is broken down—how much is for the living wage, how much is for building capacity and so on. Our other concern is that, if you put too much focus on the Scottish living wage, some of the worse providers will try to cut other terms and conditions in order to meet that—they will meet the headline in a way that enables them to say, "Yes, minister, we are paying £8.25 an hour", but they will cut travelling times, they will charge for mobile phones, they will not pay holiday pay or sleepover pay properly, and so

on. Our latest freedom of information request survey of councils indicated that most of them admit that they are not following the Scottish Government's statutory guidance in this area.

There is a solution. We accept that, in the current climate, the Government will not have the necessary money to solve all the problems in the social care sector. However, if, in April, for example, it had got Unison, the providers, the Convention of Scottish Local Authorities and so on around the table and said in an absolutely transparent way, "This is the money we have and this is what we want to deliver. Let's have a discussion about how to do that", we would have all played ball with that and we would not now be in a situation in which none of us knows whether we are going to make it by 1 October.

We need to have a national rate for home care—we have one for the residential sector and we should have one for the home care sector as well. That requires early engagement and transparency about funding, and it also requires recognition of "Unison's Ethical Care Charter", which a number of authorities are now picking up and which sets out a range of things that must be done. Pay is important, but there are other things that need to be done as well. If we had a national forum in which to have that discussion, that would allow local authorities and the integration joint boards—because, of course, the money went not to councils but to the health service, then to IJBs and then to councils, which seems to be a most bizarre way of funding anything—to focus on designing the best service delivery systems locally without having to worry about the key issues in terms of contractual rates.

Ivan McKee: On the integration aspect, one of the things that the care workers raised this morning was the difficulty that they have found in co-ordinating and getting responses from other people who are involved in the process. For example, a doctor might make an assessment and write up some notes but not tell the care worker about that assessment, so they have no idea what the patient's status is. There are also problems with getting hold of staff in other parts of the health service. Can you comment on that? The issue might relate to different types of provider—local authority, arm's-length external organisation, voluntary sector, private sector or whatever; I do not know whether that would make a difference.

Also, how are measures of patient satisfaction tracked, and what do they show?

Donald Macaskill: On the multidisciplinary dimension, we continually speak to staff in care homes and in care home services who feel that they are not valued. If your role and your contribution to the health and wellbeing of the individuals whom you are supporting is not valued by clinical colleagues in the community—whether they are general practitioners, allied health professionals or whoever—that will have a profound impact on the individuals who receive that care and support.

Let us be honest: support is piecemeal, particularly for older individuals. This morning, I read a brief summary report about how poor post-diagnostic support is for individuals with dementia in care homes. We are getting it right in the community, but we are not getting it right for individuals in the care home sector. If we are serious about integration and about valuing the unique contribution of social care staff and clinical professionals, we need not only to start talking to each other, being co-located and having teams, networks and so on, but to start collaborating around the person, who ultimately cares not about the colour of your uniform but about the difference that you make to their life. At the moment, because of a lack of interprofessional support, those things are not happening.

11:00

Miles Briggs: Some of the care workers to whom I spoke at the breakfast meeting this morning said that they were almost undertaking a community nurse role in the job that they do, given that they deal with stoma bags, with feeding people and with managing people's medication, for instance. The group of clients who require palliative care and end-of-life care is increasing. How is training being developed to address the demographics that Scotland will face? I am interested to hear of any continuing workforce training and upskilling.

Nicky Connor: You make an important point. A lot is happening on joint training, with people developing and delivering training together. Some of the tasks to which you refer do not require registered nurses to deliver them. When we consider delivering more complex care in the community, whether that is in place of acute hospital care or is palliative care, we need to ensure not only that nurses are able to deliver what only they can deliver but that there is a support network so that people do not feel dumped on or left and that we are working together.

There is a place for the development of clusters and local teams. What does that mean for nursing, the allied health professions, general practice, our social care workforce and our voluntary agencies? I have seen that approach work in practice through, for example, a daily huddle. The approach enables those in general practice to ask what using the huge amount of data that is available to us on people who are at risk means for being fluid with the workforce, so that we put

the care where people need it most. A member of social care staff who goes in four times a day to deliver care and support might notice that somebody's pressure areas are becoming red. They can then contact the nurse, who can get involved earlier, so that we get upstream and prevent problems rather than react to what happens.

There are examples of nurses absorbing tasks that do not require a nurse to do them but I agree that there is a training, support and governance need to make that safe for everybody.

The Convener: That takes us back to a couple of things that we heard at our breakfast meeting this morning. Some of the care workers told us about the new technology that they have been using, which enables them to get care plans on a smart phone, which is great. Others said that they just get a text from a manager—they no longer have any interaction with another person in the organisation. There are huge advantages to using technology, but there are also disadvantages.

Donald Cameron (Highlands and Islands) (Con): The committee has given itself the task of examining the implications of the Brexit vote. It would help us if the witnesses could give us an estimate of the percentage of EU nationals in the social care workforce. Is there any great divergence in terms of geography or internal structures? I do not know who can answer that, but Dave Watson mentioned the issue.

Dave Watson: That is right. The day after the referendum, I thought that we had better find out how many members we had who were EU nationals so I got my team working on all the usual sources, but I quickly discovered that there is no data and that we do not know. In the national health service, there is a survey of ethnicity, but it is voluntary and large chunks of staff choose not to answer it—you might be worried about why they feel that they are not able to answer it. However, the sad fact is that they do not answer it, so we do not know the answer.

We have done some work on the matter. We reckon that we have about 6,000 members in Scotland who are EU nationals. They are mostly in the health and care sector. The bulk of them are in the private nursing sector—they are mostly in Donald Macaskill's area. We have an overseas nurses group, through which I meet quite a lot of them. The honest answer is that we do not know what percentage of the social care workforce are EU nationals but we know that EU nationals are a large chunk of that group.

Some years ago, I worked in the Scottish Government's health department doing workforce planning of the sort that Annie Gunner Logan referred to. At the time, we talked about having to bring almost every young person—women and girls, certainly—into the workforce. That did not happen because migration took up the slack.

The next big jump will require 60,000 care workers, not just in social care but in healthcare, but the workforce is just not going to be available. The simple demographics tell us that there will not be enough young people, and not enough young people want to work in the sector anyway. Without a significant level of migration, I do not know what we are going to do. There are two real concerns for us about Brexit. First, as we said to the Scottish Government and your colleagues on the European and External Relations Committee, we need an absolute commitment from the United Kingdom Government that existing EU nationals will be allowed to stay. That should be said now, unequivocally, or people will start to make alternative plans and go. Secondly, we need a long-term arrangement whereby we can still recruit and retain staff from overseas, because we will need them.

Dr Macaskill: EU nationals work predominantly in the independent sector. Our most recent data is from about nine months ago. We are currently doing some research, which I hope will be available in the next few weeks. The vacancy level for nurses in the independent sector is 18 to 20 per cent. We have noted that, in the past 18 months, about 55 per cent of the people we have recruited have come from the European Community. Major care home organisations as well as smaller organisations have set up recruitment units in European cities. About 14 to 16 per cent of our membership—the largest social care workforce—were born in mainland Europe.

Because Scotland is so hospitable, we are confident that we will encourage those who are here already to stay and find a place of value and welcome here. However, as Dave Watson said, that will not help us to address the question of how we plug the gap that already exists and will only grow in future. Migration seems to be the only answer to that question.

Alex Cole-Hamilton: My question speaks to Dave Watson's earlier anecdote about providers that said "We don't do villages", and it is about the urban-rural split in social care provision. Before I became an MSP I worked for a social care provider and we did a bit of work with Angus Council. We identified that only 104 children from across that authority had been assessed as requiring respite support. That means that there is a difficult business case for a new provider looking to expand into the area, which has a knock-on effect on choice in self-directed support, as we discussed earlier, as well as implications for travel times, given that rural areas are involved. You might have a window of an hour in which to meet

somebody and support them, but it might take you 25 minutes or half an hour to get there. I ask our panellists to reflect on that scenario. How do they think that that problem will develop, and do they think that there are there any solutions to it?

Dr Macaskill: I think that there are solutions—we have seen some. We need to look north, to the Highlands and Inverness in particular. There are some innovative programmes in Boleskine, where community groups, with the support of one of our members, Highland Home Carers, have begun to develop alternative models—a workers' co-operative and a community-led model—for the provision of social care support in more rural and isolated communities. They have also been supported by NHS Highland and Highland Council. Where there is collective partnership working, we are coming up with solutions to the challenge; where there is not, the challenges only grow.

Clare Haughey: I declare an interest: I am a member of Unison.

One of the issues that were raised with me this morning was the use of zero-hours contracts, particularly within home care. That was not a short-term measure for holiday or vacancy cover; staff were employed continually on zero-hours contracts and were expected to do training in their own time, unpaid. How can social care providers justify that in the long term? What work are the IJBs or the NHS doing to ensure that organisations that contract with an IJB do not use exploitative zero-hours contracts?

Jim Fordyce: As an organisation, we do not use zero-hours contracts at all. We have 320 staff, and we have contracts with all of them. It is possible to do that, although there is a price to pay. That follows on from Ivan McKee's question about the work being spread out during the day. It is about workforce planning, too.

The local authorities with which we contract have hollowed out their services a little bit. A lot of services are provided in the morning and in the evening, but not so much in the middle of the day. That aspect has changed significantly over the past four or five years. People who want to work full-time hours have to work split shifts. That is just a fact of life at the moment. To answer Clare Haughey's point, we can guarantee people full-time hours, but it takes a lot of planning and we have to be confident that we are going to get the work.

Someone mentioned the point about attaching certain service users to a particular worker. We find that difficult to do, given the way in which services are contracted at present. If somebody went into hospital, the worker would lose all their hours, so things have to be spread out a little more. However, although it takes a bit of thought and planning, it is possible to do that—and we have always done it for a lot of people.

The Convener: We were previously told that European Union rules, single market rules and so on prevented the implementation of statutory provisions to address issues such as zero-hours contracts and the living wage. Is that the case? If so, might the situation change now?

Dave Watson: There are two points. First, the official statistics tell us that less than 10 per cent of the sector's workforce is on zero-hours contracts, but that grossly underestimates the problem. A lot of people are on what I would call nominal-hour contracts. In other words, they are not on zero hours; they have a 10-hour or 15-hour contract but regularly work 20 or 25 hours. Such a contract is as big a problem for someone in terms of getting a mortgage and having a career, and there is no doubt that it puts people off working in the sector.

That leads to the Ivan McKee's point about split shifts. It is one thing if someone has a three-hour shift in the morning and another three-hour shift in the evening with a big gap in between so that they can go home and do other things—frankly, some of our members even do other jobs in between. However, it is another thing altogether if the worker's first shift drags on till 12 and their next "shift"—I put that in inverted commas—starts at 2 o'clock. They do not have time to go home, so they just walk around and go to cafes. Throughout Scotland, you will see an awful lot of care workers doing that. In fact, we organise and carry out recruitment exercises in supermarkets because we can see care workers with their uniforms on trying to waste time before their next shift by going around supermarkets and sitting in supermarket coffee shops because they are cheap.

There have been a lot of myths around procurement. The procurement guidance that we agreed with the Scottish Government shows how to address the issues that you mentioned, convener, and it is really disappointing that local authorities seem to struggle to follow it. The guidance is not ideal, and we would like it to be clear in specifying the living wage. In our view, that can be done perfectly legally. For all sorts of reasons, however, the law officers felt that that was not possible.

It is possible under new guidance. All that has to happen is that the local authority simply specifies in its general strategy and policy on procurement what it wants to see—the living wage, secure contracts, timely care and so on. All the things in our ethical care charter can be specified, and the local authority can evaluate contracts against them. Once the contracts are awarded, the contractor is essentially agreeing to deliver those things.

It is a bit messy and complicated, but it is legal and doable. It is beyond my understanding, frankly, why local authorities say that they cannot follow the guidance.

Annie Gunner Logan: The question is very interesting. The key issue is exploitative zero-hours contracts, in the Sports Direct fashion. There are very few—if any—voluntary organisations that operate those contracts as a general package of terms and conditions for staff.

With the agreement of staff, zero-hours contracts can be very useful for relief and sessional staff. A lot of organisations operate them in co-operation with their own staff, but by and large what you are talking about does not really exist in the voluntary sector.

11:15

Dave Watson's comments about fair work are crucial and to the point. In some social care tender exercises, we have found that the fair work question is there for bidders to answer, but the weighting given in the tender evaluation is 5 per cent, whereas the cost is 30 or 40 per cent. That is where we need some change: much more weight must be given in tenders to fair work principles and practice.

Someone made a point about community-based alternatives to getting a provider's infrastructure into a village, which is very difficult and costly. The minute that you tender for that, you kill it—that would be my view.

When we started talking about Brexit with our membership, the issue that came up first was not the EU national workforce but whether our membership could follow different procurement rules, because people really want to be able to do that.

The Convener: I will bring in Iain Ramsay. I am sorry; you have been waiting for some time.

Iain Ramsay: I want to follow up on an earlier point about communication between the GP and the carer. A lot of that is based around the historical construct of multidisciplinary teams and in many ways is quite silo based. We have an opportunity, which we are pursuing, to look at why a carer has to go to their manager, who then relays information to another manager, who then relays it to another person. It does not seem sensible to have that approach.

We are moving to a location-team approach. Carers are part of that team, which is called a virtual community ward. Practitioners gather together every morning around a whiteboard that lists folk in their village or town whom they are concerned about. GPs are involved in that, too. The practitioners go through that list of people—some people are taken off list, and other people are added on. It is not a health model or a social care model; it is a joint model. Everybody in that team is respected and their views and opinions are exactly equal. Through that approach we break down some of the elitism barriers that often creep into a multidisciplinary way of working.

The Convener: What is your organisation doing in relation to zero-hours contracts? Do they operate in your area?

Iain Ramsay: I can speak only on behalf of the health and social care partnership in Aberdeenshire. Broadly, in the past we had very fixed rotas, which did not necessarily suit many people or offer a family-friendly approach. We now operate a range of shift patterns and a range of contracts, most of which are based on a set number of hours. Relief staff are part of the mix of staff as well. However, demand outstrips supply, so if people want a certain number of hours, generally they are given that number of hours. It is based on the demand, which is increasing all the time and which we struggle to meet.

Dr Macaskill: I would like to make a point about zero-hours contracts. Sixty per cent of our providers struggle to recruit staff. Employers do not enter into an exploitative situation if they want to recruit staff. By and large, employers in social care do not establish themselves to be poor employers. The issue comes back to the fair work practice process that Dave Watson and Annie Gunner Logan have talked about. Ultimately, we will get fair work conditions only if we get a fair process of commissioning and procurement. As Dave Watson has suggested, that involves us all sitting round a table and asking what it costs to give not basic care but appropriate, high-quality care and support to our citizens. That must be a national process, and it is about time that we had it. The sector—the workers, the managers and providers—are tired of constantly negotiating in different parts of the country 5p here, 10p there, 16p somewhere else. It is time for my sector, if we are serious about older people's care and support, to get round the table and start negotiating about what that looks like in practice within our limited resource.

Richard Lyle: Dr Macaskill has just touched on the point that I was going to make. I apologise to anyone who may take offence at my question, but it has not been asked yet. All care was previously done by councils—by council staff and the people who ran council homes. It has all been privatised, and everything supposedly got better. We have private care homes, private care at home and agency workers who do not go into villages because they do not do that. Have we privatised care too much? Have we got to the point where

we need to scale that back and—sorry to say this, ladies and gentlemen—renationalise care?

I have watched care workers from different agencies going into different houses in my street—different agencies going into the same street. With the greatest respect to private providers that are complaining about wages and conditions and holidays and so on, I say that they are in it to make a profit. Should we not do what Dr Macaskill said and do away with all these factors of 5p here and there, and bring care back under one umbrella, rather than all the separate umbrellas that we have at present?

Dr Macaskill: Can I respond to that, as the representative organisation of the independent sector, which includes private, charitable and not-for-profit organisations? What we want is a range of choice for citizens, so that a person can choose provider A, which is offering a particular skill set, or provider B, whether that is public, private, independent, charitable or voluntary. I think that that is ultimately what a citizen desires.

However, have we given sufficient resource to the sector? The answer is no; year on year for the past 10 years, we have reduced the amount of money allocated per capita to the care and support of older citizens. That has a profound impact on the nature and quality of the services delivered.

The fundamental question is bigger. It is not who does it but what it is that we want people to do. What is the level of care and support that we require? Eligibility criteria keep getting higher and the home help of 20 or 30 years ago who connected people with their communities has gone. Now, as we have heard, we have individuals who are engaged in highly intensive, emotionally draining work. I was going to come back on the palliative care comment, which asked whether we are ready for the palliative end-of-life needs of our community. In some areas, the answer is yes; in other areas, the person who sits with somebody who is in their last few weeks of life is terrified because she or he is not trained, or not resourced, because their organisation cannot afford it.

We need to get round the table. I do not think one answer will be the solution, but we need at the very least to start talking.

Richard Lyle: How many providers have there been in the past 20 years? Has the number doubled, quadrupled, or stayed the same?

Jim Fordyce: It is funny that you should say 20 years, as 20 years ago is roughly when we started. At that time, there were home helps who did not do much personal care. Just at that time, district nurses stopped giving things that were called at the time “social baths”; they would give only medical baths. They asked nursing or care homes to go out into the community and provide social baths. That is how a lot of care-at-home providers started in the mid-1990s—with a change in how nursing was done in the community and what the home helps could do.

Tom Arthur: One question that we have touched on many times this morning is how we value our care staff, and issues that have been raised include parity of esteem in the multidisciplinary environment. However, it goes deeper than that, and my question, which will be very short, concerns the welfare of care staff themselves. Who cares for carers? In the conversations that I was very privileged to have this morning, I was struck by the number of carers who feel on the edge of breakdown, because they are overwhelmed. How many days are lost to stress or depression? How many of our carers have been prescribed antidepressants? How many are battling with alcohol problems? Those are some of the issues that were raised directly with me this morning, and I would like to hear some comments from our witnesses on them.

Dr Macaskill: For the past two years, we have run the front-line worker project, which now has more than 100 front-line workers. A programme has been developed, and next week we are holding a day in which we and those workers will look at the emotional, personal and physical wellbeing of home care and care home staff. As you have rightly identified, they have said that, although they enjoy what is a hard, joyful job, it is increasingly tiring and draining. All of that relates to everything that we have talked about this morning. If we are to hold on to these dedicated individuals, we need to attend to their health and wellbeing. We all need to start doing that together, and we are beginning the process next week in Glasgow.

Anna Fowlie: It is difficult to achieve what you are asking for, and the only way of achieving it is, as Donald Macaskill has suggested, by running focus groups, samples and surveys and then extrapolating from them. After all, the sector has more than 7,000 employers. It is not as if you can just go out to 32 councils, 14 health boards or whatever and say, “Give us the stats for your staff.” There are thousands of employers, and they are the ones who hold the information. As I have said, what you are looking for is hard to achieve, but it can be done with sampling and so on.

Annie Gunner Logan: Perhaps I can quote again from our human resources benchmarking survey of the voluntary sector. The average number of days lost per employee was 9.9, while the figure for the economy as a whole is 8.3—and that figure was lower than it was the last time we checked it. I cannot tell you how much of that is down to the kinds of issues you have mentioned,

but I just wanted to put those stats before the committee.

With regard to Richard Lyle's point about privatisation, I hesitate to correct a member, but I have to point out that not everything was always provided by councils. A lot of care and support has always been provided by voluntary organisations; it is just that the public sector eventually caught up with us and decided to fund that care and support publicly. The question whether things should be provided by a mixed economy is perhaps a matter of political taste, but I can tell you that the quality of care and support provided by the voluntary sector for adults in Scotland is much higher than that provided in either the private or the public sector. If we are talking about the service that people get, there is a very good justification for putting more out into the voluntary sector instead of taking it back in-house again.

I also want to make a quick comment about the kinds of support that staff are getting for the issues that Mr Arthur mentioned. Donald Macaskill talked earlier about the risk with living wage implementation that people might end up with £8.25 in their pocket but other things will have to be cut to pay for that. In that respect, we are very concerned about supervision for staff, because the job is very challenging at the best of times, even if you are not doing extra hours or overtime and no matter whether you have fair work principles or not. It is therefore critical to have good management and supervisory support, and we certainly would not want to see that sacrificed in pursuit of some kind of totemic achievement of some number somewhere.

Alex Cole-Hamilton: On the back of that point, I say that I should have declared at the start of the meeting that the social care provider that I worked for was Aberlour Child Care Trust.

There is empirical evidence to show that service provision in the voluntary sector can outstrip statutory provision. For example, looked-after children in residential care in the voluntary sector have demonstrably better educational attainment and attendance, and that rich tapestry of provision is vital. Moreover, with regard to the procurement environment, when services go out to tender, voluntary sector providers often have to compete against in-house local authority providers that can hide some of their on-costs in terms of the economies of scale that they get from being so big. I therefore echo Annie Gunner Logan's point about the importance of a rich tapestry of provision.

11:30

Alison Johnstone: This is a very challenging issue. We are learning a great deal this morning about the challenges that we face in ensuring that we have enough people delivering care.

I want to explore further some of the issues that have been raised. Iain Ramsay mentioned that elitism was sometimes evident in the multidisciplinary teams. One of the groups of people I spoke to this morning said that, while GPs may engage well with them on a professional level, they often felt overlooked and undervalued, despite the fact that they had spent the most time with patients during the week.

The SSSC report, "Scottish Social Service Sector: Report on 2015 Workforce Data" highlights a steady decline in registration and certification for the Scottish vocational qualification in health and social care. We are looking at developing a culture that appreciates and values those who work in social care, but are we investing enough in their training? I heard from two people this morning who said that they worked for a private provider and had had three days' training. It is clear that the better we train all those working in the field of care, the better able they will be to deal with what is clearly a stressful and demanding role. I would like to hear your views on how well we are training staff in this area.

Anna Fowlie: With regard to the SSSC's data, we think that the decline is because most people now have the qualification. The people working in the sector have had the time to get it, so it is not that people are not doing training—it is simply that they have already met the registration requirements. That will gradually go right back to the beginning again when the care-at-home register is opened in 2017, but people who are working in care homes now have had considerable time in which to achieve those qualifications.

Alison Johnstone: Perhaps someone can pick up on whether agency staff are trained to the same specifications.

Anna Fowlie: They should be.

Dave Watson: To pick up on the point about stress, you will read in our latest survey a number of staff describing in their own words the pressure that they feel under. Increasingly, a lot of home care staff are also dealing with end-of-life situations, for which they are certainly not trained and which they will have had very little experience in dealing with.

The response from employers is mixed. We have been doing quite a lot of work with the best employers on ill health and sickness absence. In fact, part of the cost reduction has involved focusing on that aspect, and it has been very successful. The one area in which the care sector is very poor concerns dealing with violence at work. Too many employers say—and I have heard chief executives say—that it is part of the job. I am

sorry, but it is not part of the job. We have a problem with violence.

Another issue with the worst providers is that care staff tell us that they go to work when they are not well because they feel that they will be penalised if they do not. Going to see an elderly person when you are not well is obviously not a clever practice, to put it mildly. We find that those on zero-hours and nominal-hours contracts in particular are the least likely not to go to work when they are not well. They are also the least likely to report safety issues and, I am sad to say, to report abuse. I was shocked at the response when I asked a question that I had not planned to ask. I asked, "What if you saw carer abuse in a home—would you report that?" One member of staff said to me, "No, Dave, I would not—my manager wouldn't thank me for it because they'd have to do something about it." They felt that, because of the fragmented market, those involved would just go to another provider.

There are big issues in the sector. The best employers in the sector are trying to tackle those issues but, frankly, there are people at the lower end of the market who are not tackling the issues, and there are real problems to be addressed.

Iain Ramsay: I would like to follow up on Jim Fordyce's point about how health and social care has developed over the past 20 or 30 years. The demographics show that a lot of people are more mature and are being cared for at home. Many of those people are receiving end-of-life care and have conditions such as motor neurone disease or dementia. That places a huge pressure on carers, practitioners and doctors—all the members of a multidisciplinary team. It can be quite difficult caring for people in their own environment; it is the right thing to do, but how we support those individuals is critical, as is how we support the practitioners and professionals. We do that through support and supervision, having a strong team ethos, doing debriefs, and those sorts of things. If we overlook that part of it, we put far too much pressure on the individuals who are out there providing that care.

The Convener: To finish, let us quickly quiz our guests. We will be producing a report or a letter to the Government following this morning's short session of evidence. We are looking for the top line on what we should be saying; I am sure that people will have different views about what we should say. Each person has 30 seconds or a minute to tell us what we should be putting in.

Anna Fowlie: For once, I am glad to start, because I am going to say what everyone else will probably say. We need to value the workforce. The living wage cannot be our highest aspiration; it has got to be our starting point. It is more than money. We have to value the people that those people work with as well.

Iain Ramsay: I reinforce the point that Scotland has a varied geography. We are in one of the most rural parts of the country, but it is not a case of one size fits all. The integration of social care and the push towards location focus—local villages, towns and communities—are absolutely right. Working alongside community planning is essential, and communities and the third sector are incredibly important. Ultimately, we have to have staff who feel valued and who are resilient and well trained. Those are all things that have been spoken about already.

Annie Gunner Logan: We have talked about problems this morning, but it would be really good for committee members to look at what people get out of this area of work. It is very substantial.

When we examine the problems, my plea would be that we emphasise that market mechanisms and a buyer/supplier relationship for care will not solve our workforce issues. Partnership—getting all partners round the table in the way that Dr Macaskill and Dave Watson talked about—is our best hope.

Nicky Connor: It is about valuing and taking a strengths and assets-based approach. Our biggest asset is our workforce, which we should value as that.

It is also about the diversity of people's needs. People do not come in a box: they are not just an older person. It is not just mental health; there is learning disability, palliative care and frailty. It is about taking a whole-team approach, using the assets of everybody in that team to provide support to our workforce and to ensure that we focus our care on people who need it in the place they need it.

Dave Watson: Unsurprisingly, care is not delivered by robots; it is delivered by people. The workforce is key. That means that staff must have proper pay and conditions and training and, most important, must be given the time to care. If you read the surveys, that is what staff say; they say, "I want the time to care, to get the feedback".

The organisational thing that we would ask you to include is a national sectoral framework for care. The fair work convention recommended that we should have more sectoral collective bargaining in Scotland, and the Scottish Government accepted that. This is the sector where most of the money comes from the Scottish Government, so it is the easiest to deliver. If we do one structural thing, it should be to create that framework.

Dr Macaskill: I will paraphrase the words of somebody I spoke to a few weeks ago who was

brought up in care. She said:,"This is a pure dead brilliant job because I get to give back. I love my job. I love what I do. It is just a pity I get embarrassed when I go out on a Saturday night and I tell people that I work in a care home and I used to work in home care, and they say, 'What is that?' They do not value me. I want a wee bit more money—not a lot, but I want people to value me for what I do."

Jim Fordyce: This is a watershed moment. I am incredibly positive, after all the negative things that I have said.

Two things are happening. First, the living wage of £8.25 an hour is being introduced. That is a starting point. The second is the change from care being a job to being a career. Registration with the SSSC in early 2017 speaks to getting the SVQ 2 qualifications into our workforce. Those two things together will change the whole dynamic. We should celebrate what our industry is. The rewards are beginning to get a little bit better for people. The training is going to be much more formal. The feedback that we get from people who undertake the SVQ is that it is incredibly positive and empowering for them and it gives them a lot more confidence.

I am quite positive about it as long as we can build from here.

The Convener: Thanks very much to everybody for coming in this morning; it is greatly appreciated.

11:40

Meeting suspended.

11:48

On resuming—

Petition

Gender-neutral Human Papillomavirus Vaccination (PE1477)

The Convener: Item 2 is consideration of petition PE1477, by Jamie Rae, on behalf of the Throat Cancer Foundation, on the human papillomavirus immunisation programme in Scotland.

Members are aware of the work that the Public Petitions Committee has carried out on the petition. The Scottish Government has agreed to implement a targeted extension of the HPV vaccine to include men who have sex with men, up to the age of 45, who attend a genito-urinary medicine or HIV clinic. The Scottish Government has also advised that it does not propose to extend the HPV immunisation programme to adolescent boys ahead of any recommendation that the Joint Committee on Vaccination and Immunisation may make. A recommendation from the JCVI is expected in 2017.

The committee is going to look at the way in which we handle petitions, given the number of new members. More experienced members may like to be involved in that discussion. With the committee's agreement, we will leave the petition sitting with the committee until we have that discussion. Can we get agreement on that?

Members *indicated agreement.*

The Convener: Thank you. We now move into private session.

11:49

Meeting continued in private until 12:05.

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